Fletcher Allen HEALTH CARE

In alliance with The University of Vermont

By e-mail

September 18, 2009

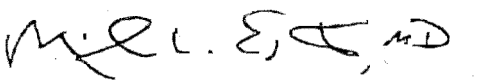
Beth Tanzman
Deputy Commissioner
Vermont Department of Mental Health
108 Cherry Street, P.O. Box 70
Burlington, VT 05402

Re: Psychiatric Acute Care Services to Replace the Vermont State Hospital – Conceptual Proposal

Dear Deputy Commissioner Tanzman:

I am pleased to submit the attached responses to the follow-up questions dated September 11, 2009, from the review committee.

Sincerely,



Melinda L. Estes, M.D.
President and Chief Executive Officer

Fletcher Allen Health Care
Conceptual Proposal – Psychiatric Acute Care Services to Replace VSH
Responses to September 11, 2009, questions

1. **Does Fletcher Allen Health Care have an expedited proposal to operate a satellite program off the main Burlington campus? If so;**
   - **Please bring it forward now,**
   - **Why this is an option at this time (e.g. what has changed?).**
   - **How would this be capitalized?**
   - **What is the timeframe and major project milestones for this option?**

   RESPONSE: No, we do not have a specific proposal in mind for an off-campus satellite program at this time. As we indicated in the Conceptual Proposal, any such program option would be explored only if the financing mechanism being developed in connection with the proposed expansion of the Rutland psychiatric unit bears fruit, since that could obviate the need for Fletcher Allen to capitalize the project directly.

   The Fanny Allen Campus is one of many sites that might be considered if capital were available. We have not promoted this location because it would require additional patient transport (from the emergency department or for certain diagnostic testing), it would be less integrated with other medical and psychiatric services at Fletcher Allen, it would require triage of patients to identify those unlikely to need emergency medical interventions, it would require a second on-call team, and its development would be delayed by the Fletcher Allen master facilities planning process. We consider off-site options to be inferior to a single integrated program on the main campus, but we are willing to consider this option if asked, and if broadly endorsed by all stakeholders in the Futures planning process.

2. **What are the capitalization options for construction of a new program on the main campus? Could FAHC capitalize this and accept enhanced rates for services over time?**

   RESPONSE: As indicated in the Conceptual Proposal and previous discussions with the State, our current planning assumes that an expansion of our psychiatric bed capacity would occur sometime in the 2016 – 2017 timeframe. The timing of that will depend on Fletcher Allen's ability to capitalize such an investment through the issuance of bonds. Also as outlined in the Conceptual Proposal, our oft-stated collaboration principles, and our ongoing discussions with the State, we would expect the State to bear the financial responsibility for both the underlying capital investment and the ongoing operating expenses associated with the expansion. Enhanced rates for services could be one option for achieving that goal.

3. Will you rely on security guards for management of acute psychiatric patients requiring restraint or seclusion?

RESPONSE: We currently use security personnel for the very rare seclusion or restraint incidents on our inpatient service. The staffing of VSH replacement units has not yet been developed, but it might very well rely on psychiatric technicians in addition to security staff as a way to provide increased staffing for behaviorally dysregulated patients.

4. How do you see this proposed program as part of the larger system to insure that every patient has a bed even if your program is at capacity?

RESPONSE: The availability of an inpatient hospital bed in a system with a finite number of inpatient beds will require that patients transition to other levels of care at the same rate that new patients enter the inpatient level of care. That balance would be achieved through collaboration with state agencies to ensure the availability of subacute care, community-based living arrangements and supervision, nursing home care, and forensic placements. It will also require that judicial referrals acknowledge the available resources and provide timely decisions about discharge**.**

5. How do you define acute care and how would the needs of patients who may stay for long periods of time be met?

RESPONSE: Acute care is brief, intense, and timely, usually designed to treat patients with immediate needs and severe illness. Severity is usually determined by the level of psychiatric symptoms, the risk posed by those symptoms, behavioral dyscontrol of the patient, concurrent medical problems, and diagnostic uncertainty.

Acute care includes the ability to provide immediate safe containment, to determine the cause or diagnosis of the presenting problem, to provide treatments that are likely to reduce symptoms in days or weeks, to provide urgent medical care, and to develop a plan for continued treatment or residential options after discharge.

Patients are no longer acute when the intensity of the problem diminishes, or when hospital level care is unlikely to lead to further improvement in symptoms.

Patients may stay for long periods of time because they are held by judicial order, because aftercare placements are not available, because their symptoms remain severe, or because applications for involuntary medications are pending. Some needs can be met by active placement of patients or by expedited judicial review. In general, patients who no longer need inpatient level of care should transition to a more appropriate residential facility. If Fletcher Allen is called upon to provide long-

term hospitalization, a subacute unit should be developed with clinical programming designed for the relevant patient population.

6. **Are there any statutory changes you feel would be necessary or important to the proposed program's success? (For instance, nonemergency involuntary medication, admission of court-ordered evaluations without physician order and retain in hospital post physician recommendation?)**

   RESPONSE: It is clinically inappropriate to withhold potentially effective treatment from patients who are so ill as to require hospitalization. Patients who lack capacity to provide informed consent are entitled to a process for substitute medical decision-making, and that process should occur in a matter of hours and days, not weeks and months. These issues may require statutory changes.

   In addition, statutory changes may be needed to authorize the State to provide the long-term financial assurances and commitments that are essential to Fletcher Allen's participation in a project of this nature, consistent with our Collaboration Principles.

7. **The collaboration principles set forward by FAHC in this proposal state that the VSH replacement service "is a fundamental obligation of the State. . . " How then do you see the mission of FAHC and its role in providing tertiary care to the most seriously ill in Vermont?**

   RESPONSE: Fletcher Allen's mission is to improve the health of the people in the communities we serve by integrating patient care, education, and research in a caring environment. Our continued willingness to participate in planning for how to care for Vermonters with the most serious psychiatric illnesses reflects that mission.

   The collaboration principle the question refers to is consistent with that mission. It is intended to ensure that the State continues to shoulder its historic obligation to care for the most vulnerable Vermonters – those with mental illnesses – even if some of those services are provided clinically through Fletcher Allen. It is also intended to ensure that Fletcher Allen's participation in this project does not come at the expense of our ability to care for the rest of our community, both as Vermont's major tertiary care referral hospital and as the primary and secondary care provider for Chittenden and Grand Isle Counties.

8. Please specifically identify inconsistencies you see between the FAHC collaboration principles and the collaboration framework set forth by DMH in the RFP.

RESPONSE: Fletcher Allen's Collaboration Principles include the following concepts:

- That the State has a fundamental obligation to provide the psychiatric care that is now provided at VSH and is to be provided in the future by the Futures Project, and that accordingly, the State will pay all capital, planning and unreimbursed operating costs of the Project.
- The the Project will not have any adverse impact on the finances or financial condition of Fletcher Allen, our debt capacity, or our ability to fund and implement other capital projects.

The Guiding Principles in the RFP, particularly the Fiscal Principles, do not provide assurances on these points. Rather, the State's Guiding Principles appear to indicate that the costs of the VSH Futures Project would be shared by the State and participating providers, including Fletcher Allen, on some basis to be determined in the future, with the State wishing to transfer some portions of the capital and operating costs of the project to providers.

As a general matter, we note that the Guiding Principles also include a level of detail as to the planning and operationalizing of any replacement project that we are reluctant to comment on in the absence of a concrete proposal.